Lewisham and Greenwich
NHS Trust

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31 October 2019

Ms B Ballard, HM Assistant Coroner
HM Coroner's Office – Inner London South
Southwark Coroners Court
1 Tennis Street
London
SE1 1YD

Sent via email only to: [redacted]

Dear Ms Ballard

Re: Mr Francis Hodge – Regulation 28: Prevention of Future Deaths

I write in response to your Regulation 28 report following the inquest into the death of Mr Francis Hodge. Thank you for highlighting your concerns, in respect of this case, which I have now had the opportunity to look into. The response required from Lewisham and Greenwich NHS Trust (hereafter 'the Trust') is in relation to the following concerns:

(1) Mr Hodge was given inadequate advice on his discharge from hospital after surgery.
(2) No patient information leaflet existed for this type of surgery as it was not a common type of procedure.

Mr Hodge underwent an elective laparoscopic repair of multiple incisional hernias at University Hospital Lewisham on 9 November 2018. Sadly, he died seven days later, on 16 November 2018, at the same hospital, from a perforated colon.

On discharge from hospital, after his elective surgery, he was verbally advised to rest as much as possible and that, if he continued to be in severe pain, in a week's time, he should return.

At the inquest, the consultant who undertook the surgery explained that such discharge advice was not what should have been provided to a patient following this surgery. Mr Hodge should have been told to be concerned about and to look out for:

- breathlessness, pus or redness, and / or pain which would not settle.

Mr Hodge was suffering from breathlessness the night before his collapse and pain which would not settle. He, however, did not want to seek medical advice because he was following what he had been told to do on discharge.

Mr Hodge was given verbal advice only, upon his discharge from hospital, following elective surgery. Patients listed for elective surgery at the Trust should be given an information leaflet at their preoperative assessment appointment.

About four years ago, the Trust commissioned a service from a company called Eido Healthcare, whereby a library of nearly 400 treatment-specific patient information leaflets can be accessed, printed and handed to patients at their preoperative assessment appointment. These leaflets form part of the informed consent process and provide specific information regarding the procedure as well as relevant phone numbers for the patient to contact in case of concerns. Mr Hodge should have been handed the information leaflet specific for laparoscopic hernia repair. However, on review of his case notes, it cannot be demonstrated that this leaflet was handed to him and I apologise for this omission.

The Trust has commenced a communication exercise to remind staff in preoperative assessment to ensure that the appropriate information leaflet is handed to patients and to document that this has been done. An audit of the provision of these leaflets will be completed by December 2019 to ensure that the communication strategy has been effective.

These information leaflets are available online and their availability is going to be included in the induction programmes of newly appointed medical staff with an emphasis on providing these leaflets during consultation.

I sincerely apologise to Mr Hodge's family for the distress caused by his untimely death after a planned surgical procedure.

Please accept my assurances that lessons have been learned from this case and appropriate actions have been put in place to address the issues raised. If you require anything further then please do not hesitate to contact me.

Yours sincerely,

Dr Elizabeth Aitken
Medical Director